

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05325

CERTIFICATE OF DEATH

Reg. Dist. No. 290

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

1. PLACE OF DEATH:

County TalbotCity or town Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 1/2 hours

Hospital, institution, or street address where death occurred:

The Memorial Hospital - Easton, md.How long in hospital or institution? 13 1/2 hours

3. (a) FULL NAME

Bessie Bailey4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) July 10, 1888 6.(c) If alive, give age years8. AGE: Years 58 Months 11 Days 12 If less than one day hrs. min.9. Birthplace Talbot Co.
(Town, county, and state)10. Usual occupation 14. W.

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mayorial Hospital
Address Easton, Md.17. Burial, cremation, or removal? Burial Date thereof 6-23-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Trappe Location Trappe, Md.18. Funeral director Lewis H. Baynes
Address Cambridge, Md.19. (Date rec'd by registrar) 6/23/47 19. N.S. Nease
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Trappe
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 - 1947, at 5:15 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw her alive on 19. to 19.

Immediate cause of death

ShockDue to ext Bilat fract. femurDue to Auto accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

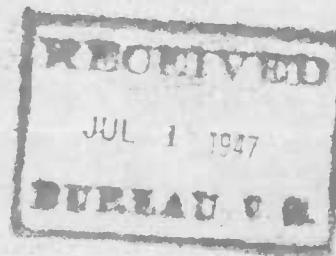
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of June 22-1947Where did injury occur? Trappe (City or town) Talbot (County) Md. (State)Injured at home, farm, industry, public place (where?) Trappe-HillwayMeans of injury Auto accident Injured at work?23. SIGNATURE Louis J. Kelly, M.D. Dr. Kelly

M. D. or other

Address Easton, Md. Date signed 6-23-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

05326

CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH:

County

Talbot

City or town

Easton Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

43 days

Hospital, Institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

Easton - 43 days

3. (a) FULL NAME

Mrs. Eva Broughman

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Charles J Broughman

7. Birth date of deceased (mo., day, yr.)

5/30/73

6. (c) If alive, give age years

8. AGE:

Years
74 yrs.

Months

Days
22

It less than one day

hrs.
min.

9. Birthplace

Clyde N.Y.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Darwin Van Lyne

12. Name..... Darwin Van Lyne

13. Birthplace..... Clyde N.Y.

14. Maiden name..... Dorothy Wood

15. Birthplace..... England

16. Informant..... Jane B. Fortune

Address..... Easton Md.

17. Burial, cremation, or removal?..... Removal

Date thereof..... June 24/73
(month) (day) (year)

Cemetery or crematory..... Evergreen

Location..... Easton Md.

18. Funeral director..... Munro & Neerup & Son

Address..... Easton Md.

19. (Date rec'd by registrar)

6/23

19 47

N.H. Neerup

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Delaware County

City or town..... Seaford

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 107 Cannon Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 6-22-1947 at 3 50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9 AM 1947 to 22 June 1947
and that I last saw him alive on 22 June 1947

Immediate cause of death..... Bronchopneumonia

DURATION

7 days

Due to.....

Due to.....

Other conditions..... Fractured hip - left

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accidental Date of 25 Apr 1973

Where did injury occur?..... Seaford (City or town) Delaware (State)

Injured at home, farm, industry, public place (where?)..... home

Means of injury..... free

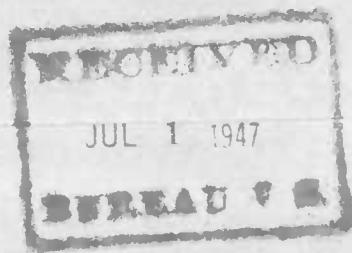
Injured at work?

23. SIGNATURE.....

Ruthie Harrison M.D.

Address..... 22 Mayland Date signed 27 June 73
M. D. or other

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05327

170c

CERTIFICATE OF DEATH

Reg. Dist. No. 292

1. PLACE OF DEATH: Talbot
 County: Talbot
 City or town: Talbot (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Talbot County: Talbot
 City or town: Talbot (If outside city or town limits, write RURAL and give nearest town)
 Street No.:
 (If rural, give LOCATION)

3. (a) FULL NAME

Joseph Brown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	widowed
<u>Rosetta Brown</u>		
6.(c) If alive, give age years		
7. Birth date of deceased (mo., day, yr.) <u>Aug 17 1875</u>		
8. AGE: Years Months Days If less than one day		
71 10 4 hrs. min.		
9. Birthplace: <u>Talbot Co Md.</u> <small>(Town, county, and state)</small>		
10. Usual occupation: <u>Farm laborer</u>		
11. Industry or business: <u>Farm</u>		
12. Name: <u>James Brown</u>		
13. Birthplace: <u>North Carolina?</u>		
14. Maiden name: <u>Margaret</u>		
15. Birthplace:		
16. Informant: <u>Henry Brown</u>		
Address: <u>Talbot Co Rd</u>		
17. Burial: <u>Burial</u> Date thereof: <u>June 24 1947</u> <small>(Burial, cremation, or removal. Which?)</small> (month) (day) (year)		
Cemetery or crematory: <u>Scott & M E C</u>		
Location: <u>Talbot (rural)</u>		
18. Funeral director: <u>Lewis A Dayneau</u>		
Address: <u>Bowbridge</u>		
19. June 24 1947 <small>(Date rec'd by registrar)</small>		

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22 1947 at CIA

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death:

Disintegration

Due to: Auto accident

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of..... 6-22-47

Where did injury occur? in Talbot Co Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) in way

Means of injury auto accident Injured at work? No

23. SIGNATURE: Louis J. Hough Jr. D.P.H.S.

M. D. or other

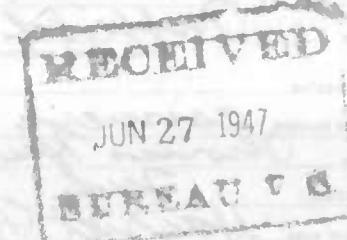
Address: Easton Md Date signed 6-23-47

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC SAFETY

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS DEPARTMENT OF PUBLIC SAFETY

REGISTRATION AND RECORDS DIVISION



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05329

CERTIFICATE OF DEATH

Reg. Date. No. 290

1. PLACE OF DEATH:
County Talbot

City or town Easton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3.(a) FULL NAME
Penruette Camper

4. Sex F 5. Color or race B. 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife Lewis Camper

7. Birth date of deceased (mo., day, yr.) 12/27/92 6.(c) If alive, give age years

8. AGE: Years 55 Months Days If less than one day hrs. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation H.W.

11. Industry or business

12. Name Samuel Green

13. Birthplace Troop, Md

14. Maiden name Sue Cromwell

15. Birthplace Troop, Md

16. Informant Lewis Camper

Address Husband

17. Burial Burial Date thereof 6/18/47
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Troop, Md.

Location Troop, Md.

18. Funeral director LeMoyne H. Baughman

Address Cambridge, Md.

19. 6/16/47 19. 47 R.L. Nease

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Talbot

City or town Easton
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/15 19. 47, at 10:35 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, 10, 19.

and that I last saw h. alive on 19, 10, 19.

Immediate cause of death _____

Cerebral hemorrhage DURATION 3 days

Due to Essential hypertension

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

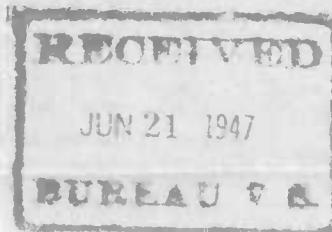
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Louis J. Nease, Jr. M.D. or other _____

Address Easton, Md. Date signed 6-16-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05330

CERTIFICATE OF DEATH

Reg. Dist. No. 293

1. PLACE OF DEATH:

Baltimore Tallard

County.....

Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ella Webster Charles

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

April 18th 1862

8. AGE:

85

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Md (Town, county, and state)

10. Usual occupation.....

House work

11. Industry or business.....

James R. Webster

12. Name.....

MOTHER FATHER

13. Birthplace.....

Lucy A. Parker

14. Maiden name.....

Mrs. Spence Webster

15. Birthplace.....

Troy

16. Informant.....

Burial

J. Burlock

Address.....

Burial

Cemetery or crematory.....

Benefield

Location.....

East New Market

4th & Willoughby

18. Funeral director.....

J. B. Willoughby

Address.....

J. Burlock

19. (Date read by registrar)

19

(Date read by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

St. Mary's

City or town.....

East New Market

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

3 June 1947 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr

19

to

3 June

19

1947

and that I last saw her alive on

20 May

1947

Immediate cause of death.....

Brain abscess and

DURATION

7 days

Due to.....

Due to.....

Other conditions.....

Arthritis chronic

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Burton Harrison M.D.

M. D. or other

Address.....

Eston

Date signed.....

June 1947

RECEIVED

JUN 17 1947

BUREAU C S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05331

161a

CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH:

County.....

City or town.....

Jacob
Baltimore R.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Ronald Lee Conrad

4. Sex

Male White Infant

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

June 4, 1947

6.(c) If alive, give age..... years

8. AGE:

Years 0 Months 0 Days 18 If less than one day hrs. min.

9. Birthplace.....

(Town, county, and state) Baltimore, Maryland

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name..... Henry E. Conrad

13. Birthplace..... Md.

14. Maiden name..... Esther Lucille Stink

15. Birthplace..... Md.

16. Informant..... Mr. Henry E. Conrad

Address..... Baltimore, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... June 5, 1947

(month) (day) (year)

Cemetery or crematory..... Spring Hill

Location..... Baltimore, Md.

18. Funeral director..... Ronald Clark

Address..... Baltimore, Md.

19. (Date rec'd by registrar)

1947

Date of death..... June 5, 1947

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 4

1947, at..... 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Congenital atelectasis

Due to.....

Due to.....

Other conditions..... Multiparity

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

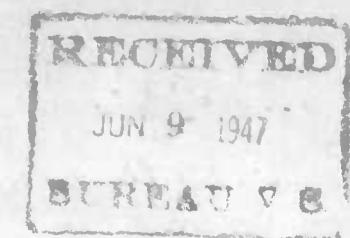
Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE..... Louis M. Kelly, M.D. D.P.M.

M. D. or other

Address..... Baltimore, Md. Date signed..... June 5, 1947



3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05332

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 292

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or

Jew

60

Married

6. (b) Name of husband or wife.....

Daniel Green

7. Birth date of deceased (m., d., yr.)

Nov. 28 1878

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

Baltimore, Md.

10. Usual occupation.....

House work

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

17. Burial (Burial, cremation, or removal; which?)

Cemetery or crematory.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

1947

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 24

1947, al. 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15, 1947, 10 June 20, 1947

and that I last saw h. e. alive on June 15, 1947

Immediate cause of death.....

Coronary occlusion

Due to.....

Arteris sclerosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

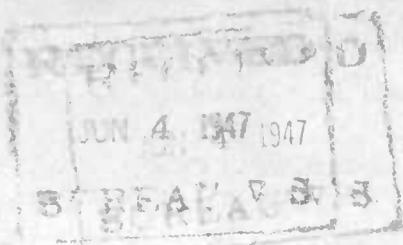
23. SIGNATURE.....

M. D. or other

Address.....

Graphe

Date signed June 30 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97
05333

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred:

S. Dover St.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

Patrick L. Young

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

January 2, 1862

8. AGE:

Years

Months

Days

11 less than one day

hrs.

min.

9. Birthplace

Kent Co. Delaware

(town, county, and state)

10. Usual occupation

Retired

11. Industry or business

John P. Griffin

12. Name

Delaware

MOTHER FATHER

13. Birthplace

Pachael George

14. Maiden name

John P. Griffin

15. Birthplace

Delaware

16. Informant

Wm. J. H. Smith

Address

Baltimore, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

January 30, 1947

(month) (day) (year)

Cemetery or crematory

Baltimore

Location

Baltimore, Md.

18. Funeral director

J. G. Clark

Address

Baltimore, Md.

19. (Date rec'd by registrar)

6/30

1947

N.H. Morris

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

Balbot

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

S. Dover St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 28

1947, at

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March

1947, to

6/1/27/1947

1947

and that I last saw h..... alive on

6/1/27/1947

1947

Immediate cause of death.....

Arteriosclerosis generalized

Due to.....

Due to.....

Other conditions

Pyoderma

Tons.

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

J. B. Cox MD

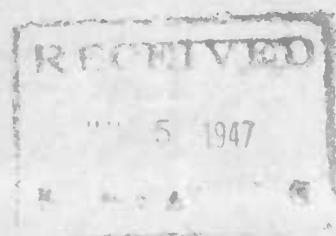
M. D. or other

Address.....

Easton Ind

Date signed.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05334

R90

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Dorothy Lee Harris

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M.C.N.

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

March 31, 1967

6.(c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

3

,

hrs. min.

9. Birthplace

Newtown, Talbot, Md.

(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

Kelvin Copper

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

Date thereof (month) (day) (year)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Newtown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1967 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 13, 1967 to June 14, 1967and that I last saw her alive on June 13, 1967.

Immediate cause of death

Promulgated pneumonia

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Kent Edder M.D.

M. D. or other

Address Anne Arundel Co.Date signed 6/16/67



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05335

181

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot Co.
City or town Federalsburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 hrs.Hospital, institution or street address where death occurred:
Easton Memorial HospitalHow long in hospital or institution? 15 hrs.

3. (a) FULL NAME

John Henry Holland4. Sex Male 5. Color or race negro 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Frances Holland7. Birth date of deceased (mo., day, yr.) 2/29/81 6. (c) If alive, give age 72 years8. AGE: Years 66 Months 3 Days 24 If less than one day hrs. min.9. Birthplace Federalsburg, Md.
(Town, county, and state)10. Usual occupation Laborer11. Industry or business Canner12. Name Romas M. Holland13. Birthplace underwood Caroline Co. Md.14. Maiden name Frances E. Shepard15. Birthplace Caroline Co. Md.16. Informant Frances HollandAddress Federalsburg, Md17. Burial Date thereof 6/26/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Federal HillLocation Federalsburg, Md.18. Funeral director J. T. Ambler Son.Address Federalsburg, Md.19. (Date rec'd by registrar) 6/24/47 19 47 M.D. or other
Address 181, Federalsburg, Md. Date signed 6/25/47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Federalsburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 19 47, at 3 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-22 19 47, to 6-23 19 47and that I last saw h alive on 19.

Immediate cause of death

Shock

Due to

Second + third degree burns 15 hrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

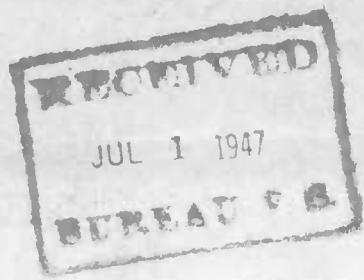
Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6/22/47Where did injury occur? Federalsburg (City or town) Caroline (County) Md. (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Burns Injured at work? No23. SIGNATURE J. T. B. Ambler M. D. or otherAddress 181, Federalsburg, Md. Date signed 6/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107
05336

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County BaltimoreCity or town Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Memorial HospitalHow long in hospital or institution? 7 days

3. (a) FULL NAME

Kilmer, George

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white Married

8. (b) Name of husband or wife

Edith Kilmer

7. Birth date of deceased (mo., day, yr.)

Sept 28, 1882

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

64 00 78 + 21 hrs. min.

9. Birthplace

Kilmer, Kansas

(Town, county, and state)

10. Usual occupation

Coproprietor Texaco Oil Co

11. Industry or business

Tepal Oil Co.

MOTHER

FATHER

Charles KilmerSyracuse, N.Y.

13. Birthplace

Syracuse, N.Y.

14. Maiden name

Mary Tracy

15. Birthplace

El Paso, Texas

16. Informant

George Kilmer

Address

New York, N.Y.

17. Burial

BurialSpring Hill CemeteryDate thereof 6/23/47

(month) (day) (year)

Cemetery or crematory

Spring Hill Cemetery

Location

Easton, Md.

18. Funeral director

J. Virgil Moore & Son

Address

Denton, Md.

19.

6/20

(Date rec'd by registrar)

19. 47J. H. Neerup

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty CarolineCity or town Denton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

19 June 1947 at 12:59A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 June 1947 to 19 June 1947and that I last saw him alive on 19 June 1947 at 19 June 1947

Immediate cause of death

Osteoarthritis lung rt(Pain of)
Osteoarthritis lobe rt

Due to

Due to

Other conditions

Osteoarthritis lobe(Include pneumonia, if any, at time of death)

Major findings of operations

Osteoarthritis lobeperforated Date of op. 6/14/47obliteratedno

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

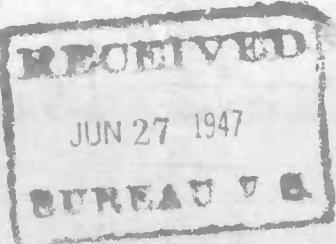
Injured at work?

23. SIGNATURE

Dr. J. D. Hoble

M. D. or other

Address Denton, Md.Date signed 6/23/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05337

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County.....

Talbot Co.

City or town.....

Easton Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

4 days

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

4 days

3. (a) FULL NAME

Margaret King

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband

James King

7. Birth date of deceased (mo., day, yr.)

deceased (mo., day, yr.)

6. (c) If alive, give age..... years

1915

8. AGE:

Years

Months

Days

If less than one day

32

hrs.

min.

9. Birthplace.....

Talbot

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

12. Name.....

Western Cancer

13. Birthplace.....

Western Shore, Md

14. Maiden name.....

Lester

15. Birthplace.....

"

16. Informant.....

James King

Address.....

Chester, Md.

17. Burial.....

Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Wardside Md

Location.....

Wardside Md

18. Funeral director.....

James A. Henry

Address.....

222 Cedar St. Cambridge Md

19. (Date rec'd by registrar).....

1947 N.Y. Necro

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Queen Anne

City or town..... Chester Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 6-19- 1947, at 1 40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 June 1947 to 19 June 1947

and that I last saw her alive on 15 June 1947

Immediate cause of death.....

Pneumonia, bilateral

Due to pneumonia, suddenly became so short of breath

from the vagina and passed two fuses approx.

4 in long. The died of respiratory failure secondary

to infection, etc. and died.

Other conditions..... Abortion, spontaneous

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

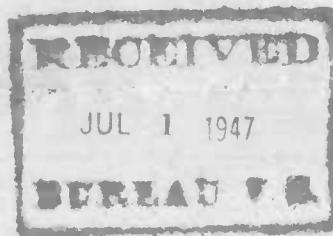
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... James A. Henry M.D. or other

Address..... Carter Bay Lane Date signed 24 June 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05338

92d

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County.....

Salisbury

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

4 1/2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Henry Mc Clement

3. (b) Social Security Number

none

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white widowed

B. (b) Name of husband or wife.....

Annie Bishop Mc Clement

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Feby - 11 - 1862

8. AGE:

Years

Months

Days

If less than one day

85 3 28 hrs. min.

9. Birthplace.....

Towson Co Maryland

(Town, county, and state)

10. Usual occupation.....

Farmer

(Retired)

11. Industry or business.....

Henry Mc Clement

FATHER

12. Name.....

Delaware

MOTHER

13. Birthplace.....

Martha Lacombe

14. Maiden name.....

Delaware

15. Birthplace.....

Lola Mc Clement

16. Informant.....

Address

514 Goldsboro St. Easton, Md

17. Burial

(Burial, cremation, or removal, which?)

Date thereof.....

June 11-47 (month) (day) (year)

Cemetery or crematory.....

Chestertown

Location.....

Centerville Maryland

18. Funeral director.....

Bailey Bros

Address

Centerville, Maryland

19. (Date rec'd by registrar)

6/9 1947 H. H. Nease

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Salisbury

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No. 847 for 4 1/2 years Room Ann C. no

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

June 11 1947 at 7 P.M.

CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st to June 11th 1947, and that I last saw him alive on June 11th 1947.

Immediate cause of death.....

Chronic Valvular Disease of the heart

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... 619 1/47 Date signed.....

RECEIVED

JUN 17 1947

BUREAU F.B.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05339
133a

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:

County.....TalbotCity or town.....St. Michaels

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....Five years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Noah Asbury Moore

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MaleBlackMarried

6.(b) Name of husband or wife.....

Mary Moore6.(c) If alive, give age.....63 years

7. Birth date of deceased (mo., day, yr.)

January 26, 1884

8. AGE:

Years

Months

Days

If less than one day

63524

hrs.

min.

9. Birthplace.....

Wetipquin, Maryland.

(Town, county, and state)

10. Usual occupation.....

Laborer

11. Industry or business

MOTHER/FATHER

12. Name.....John Moore13. Birthplace Wetipquin, Maryland.

MOTHER/FATHER

14. Maiden name.....Mary E. Wilson15. Birthplace Quantico, Virginia.16. Informant.....Arletta Horsey

Address

McDaniel, Maryland.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof.....June 26, 1947
(month) (day) (year)

Cemetery or crematory

Sherwood Cemetery

Location

Sherwood, Maryland.18. Funeral director.....J. Norman Marshall

Address

St. Michaels, Maryland.19. 6/26.....1947

(Date rec'd by registrar)

Mrs. Robt. L. Seth

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....TalbotCity or town.....St. Michaels (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

212-12-3243

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....June 23 1947 at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 23 1947 to June 23 1947and that I last saw h. in alive on June 23 1947

Immediate cause of death.....

Cerebral

DURATION

2

Due to.....

Pyelonephritis5 days

Due to.....

Other conditions.....Pallorosa (Hypostasis)24 hrs.

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

• Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

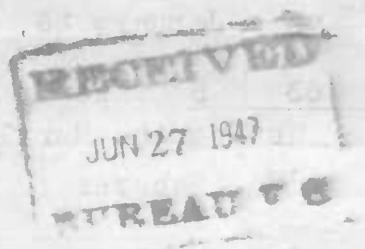
Injured at work?

23. SIGNATURE.....

Arthur J. Nichols, M.D.

M. D. or other

Address.....St. Michaels, Md. Date signed 6-24-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

053411

CERTIFICATE OF DEATH

Reg. Dist. No. 299

1. PLACE OF DEATH:

County

Talbot

City or town

Edenton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

25 min

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?.....

25 min

3. (a) FULL NAME

Nellie

O'Brien

3. (b) Social Security Number

none

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

6. (b) Name of husband or wife

James O'Brien

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo. day, yr.)

Feb. 20 1873

8. AGE:

Years
74Months
4Days
1If less than one day
hrs. min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Rooming House Operator

11. Industry or business

Unknown

FATHER

12. Name

Unknown

MOTHER

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mrs H. Sherman Daily Jr.

Address

327 West Lorraine Street

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof: June 23, 1947
(month) (day) (year)

Cemetery or crematory

Cemetery

Location

Rehoboth, Ind.

18. Funeral director

Rehoboth Funeral Home

Address

St. Michaels, Md.

19. (Date rec'd by registrar)

1947

N.Y. Nurses

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot

City or town Edenton

(If outside city or town limits, write RURAL and give nearest town)

Street No. Dawson Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

6-21-1947 at 12:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 9, 1946, to June 21, 1947

and that I last saw her alive on June 21, 1947

Immediate cause of death

Intra cranial hemorrhage

DURATION

24 hrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

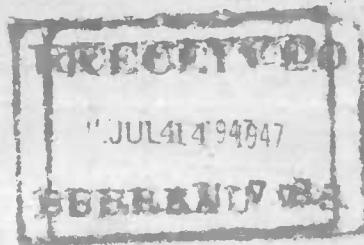
Walter F. Bellard

M. D. or other

Address.....

Edenton, NC Date signed 7-8-47

RECEIVED
FBI - NEW YORK



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item
is especially important. Physicians: please write the cause
of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05341

CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH:

County... Talbot

City or town... Rural Weston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... 15 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) NAME

Pearce Hughes Roberts

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M W Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan 11 1878

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

68

4

20

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

Theatre Stage

12. Name.....

Pearce Hughes

13. Birthplace

Md.

14. Maiden name.....

Pearce Gordon Portland

15. Birthplace

Md.

16. Informant.....

My Husband Pearce

Address.....

Easton, Md.

Cemetery or cemetery

Decomposition

Location.....

Portion of Md.

18. Funeral director.....

J. T. B. Ambler

Address.....

Box 116, Md.

19. (Date rec'd by registrar).....

1947

M. D. or other

Address.....

Easton, Md.

Date signed.....

6-2-47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Talbot

City or town... Rural Weston

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 1 1947 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-1 1947, to 6-1 1947

and that I last saw h. s. alive on 6-1 1947

Immediate cause of death.....

Coronary Thrombosis

DURATION

1/2 hr.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... not obtained

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

J. T. B. Ambler M. D. or other

Address.....

Easton, Md. Date signed.....

6-2-47

RECEIVED

JUN 17 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05342

CERTIFICATE OF DEATH

Reg. Dist. No. 292

1. PLACE OF DEATH:

Talbot

City or town: Easton Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

47 days.

Hospital, institution, street address where death occurred:

2-5 Star Memorial Hospital

How long in hospital or institution?

47 days.

3. (a) FULL NAME

Mrs. Nattie Scharch

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

Frances L. Scharch

7. Birth date of deceased (mo. & yr.)

6. (c) If alive, give age

years

1894

8. AGE:

Years

Months

Days

If less than one day

53

hrs.

min.

9. Birthplace

(Town, county, and state)

Talbot Co.

(Town, county, and state)

Md.

10. Address

11. Indus.

Business

12. Name

Mother Father

Robert J. Ridgeway

Virginia

13. Birthplace

Maryland

Greens L. Sinclair

14. Maiden name

Maryland

Maryland

15. Birthplace

Easton

Memorial Hospital

16. Informant

Daniel

Address

Easton Md.

17. Burial, cremation, or removal. Which?

Date thereof

(Burial, cremation, or removal. Which?)

(month)

(day)

(year)

Date of op.

Cause

Date of op.

Cemetery or crematory

Location

D. O. M. or other

Address

St. Michaels

Date signed

VS A15

Date rec'd by registrar

1947

F. H. Morris

Registrar

Date signed

1947

John S. Hoble

M. D. or other

Address

Easton Md.

Date signed

1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Talbot

City or town

Tilghman

MD

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 28 1947 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 14 1947 to June 28 1947,

and that I last saw her alive on June 28 1947.

Immediate cause of death

Cerebral hemorrhage of
Wall of bladder

DURATION

1947

Due to

Due to

Other conditions

Cholelithiasis etc

1947

Cholelithiasis

(Include pregnancy within 3 months of death)

Major findings or operations

Adhesions of GB with
colon to liver - Meant to
resection to liver - Meant to

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John S. Hoble

M. D. or other

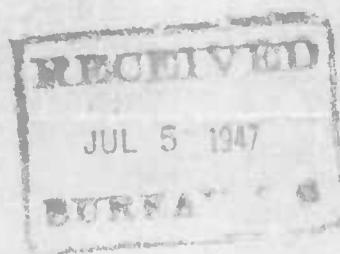
Address

Easton Md.

Date signed

1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page
is especially important. Physicians: please write the causes of death clearly and legibly.

, FOR BINDING

05343

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

CERTIFICATE OF DEATH

Reg. Dist. No. 29

1. PLACE OF DEATH: Talbot
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME Jennyson Turner

3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) about 1905 6. (c) If alive, give age years

8. AGE: Years 42 Months v Days v If less than one day hrs. min.

9. Birthplace Easton Md.
(Town, county, and state)

10. Usual occupation Day laborer

11. Industry or business

12. Name Isaac Turner

13. Birthplace Easton, Md.

14. Maiden name Georgiana Boddy

15. Birthplace Groves, Ga. Md.

16. Informant Isaac Turner

Address Easton, Md.

17. Burial Burial Date thereof June 26-47
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory A.A.

Location Easton, Md.

18. Funeral director Lewis H. Carpenter

Address Cambridge, Md.

19. June 26, 1947 Joseph L. Johnson Local Registrar
(Date rec'd by registrar) Registrar (Signature) Local (Title) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1947 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death

Auto accident

DURATION

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6-22-47

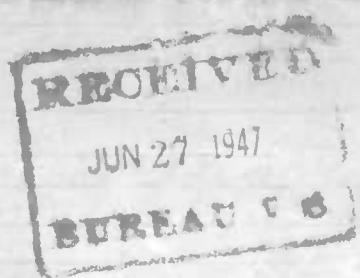
Where did injury occur? Talbot (City or town) Talbot (County) Md. (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury auto accident Injured at work? No

23. SIGNATURE Louis J. Neely, D.P.H.S. M. D. or other

Address Highway Date signed 6-23-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92d
05344

CERTIFICATE OF DEATH

Reg. Dist. No. 292

1. PLACE OF DEATH:

County.....

City or town.....*Talbot*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Noah Morris Wilson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Negro Widower

B.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

March 20 1876

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

71

6

8

hrs. min.

9. Birthplace.....

Trappe Talbot Co. Md

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business.....

Farm

12. Name.....

*Albert Wilson**Rural*

13. Birthplace.....

Trappe Talbot Co. Md.

14. Maiden name.....

*Henrietta Blake**Rural*

15. Birthplace.....

*Trappe Talbot Co. Md**Norman Wilson*

16. Informant.....

Burial

Address

Trappe Talbot Co. Md

17. Burial

July 1 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Trappe Cemetery

Location.....

Trappe Talbot Co. Md.

18. Funeral director.....

H.H. Sollars & Son

Address

Cambridge Md.

19. June 30-1947

Death rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland*County.....*Saint Mary's*City or town.....*Trappe (rural)*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 28

1947 at 130 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

bleeding

1947 to June 28 1947

and that I last saw him alive on

June 28 1947

Immediate cause of death.....

Chronic Endocarditis

DURATION

2 years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Howard T. Webb M.D.

M. D. or other

Address.....

Easton, Md.

Date signed

6/29/47

D. Ross

